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ABSTRACT

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Reducing Psychiatric Inpatient Violence through Solution-Focused Group Therapy

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Increasing emphasis on deinstitutionalization, coupled with managed care organizations' avoidance of costly inpatient treatment, have resulted in changes in the modal characteristics of patients in psychiatric hospitals. As symptom severity and level of impairment supplant diagnosis in determining patients' level of care, self injurious and other violent behaviors provide the basis for an increasing number of hospitalizations. This has resulted in a growing concentration of patients with a history of violence in many inpatient psychiatric facilities.

Solution-Focused Treatment

Many managed care organizations are encouraging behavioral healthcare providers to make use of solution-focused psychotherapy techniques. For example, in September 1997 a CIGNA/MCC representative urged providers to be solution-focused, to emphasize the individual's strengths rather than pathology, and to utilize very short-term (6 or fewer sessions) outpatient treatment duration.

Such policies are prompting greater consideration of whether solution-focused therapy is appropriate or effective for all patients. Relatively few investigations of the effects of this method on inpatient populations have been conducted to date. There have also been few assessments of solution-focusd treatment administered in group format.

In Solution-Oriented Therapy (Hudson O'Hanlan,1993), emphasis is placed on the varied ways that therapists can help patients find their own solutions through specific forms of communication. Some of the communication techniques suggested include:

- Acknowledging the person's point of view to develop rapport
- Creating an expectation for change with solution-oriented language
- Identifying the first signs that will indicate movement towards the therapeutic goal
- Casting doubt on suggestions or actions which close the possibilities for finding a solution
- Listening for things that support change for the better
- Reinforcing the understanding that change will occur in small steps
- Reinforcing other people's competence and skills to help with the patient's problem

Initial Approach

Therapists' begin with comments such as: "I am very sorry to hear how things are going. Can you tell me what about this you would like to change or in what ways you would like to be handling things differently?" This type of question supports the patient's feelings and asks a goal-oriented question in which she or he is invited to state the goal in terms of changing or an action response.

For example, the patient might say, "Well, I want to be able to leave the hospital, and I know to do that I need to stop cutting whenever I get upset about something."

This method focuses on defining clearly operationalized goals with the patient. In the group, articulating individual's goals enables more constructive mutual support among members throughout the week.

Next, the solution-focused method explores times when patients have already behaved in line with their objectives. These "exceptions" highlight the individuals' capacity to achieve their goals and the strengths that already exist within. Reducing the perceived difficulty of making a change increases the probability of the patient's making enduring and maintainable progress.

Solution-focused therapy also encourages patients to visualize adaptive alternatives, and to think specifically and concretely about how they would prefer to be living. Therapists make use of the "Hypothetical Solution Frame" to clarify

patients' goals: "If a miracle happened, and the problem were solved, what would you be doing differently?" This is an adaptation of Erickson's crystal ball technique (Erickson, 1954). The idea behind the technique was to have the patient create a representation of a future with the problem solved or without the problem, to have the patient look backward from the future toward the present and identify how she/he reached a solution.

Method

This study targeted a group of 16 high-risk patients with a recent history (during the past year) of violent responding within the treatment setting. A solution-focused treatment approach was used in conducting two ongoing weekly therapy groups, each with 7-8 patient members usually in attendance.

Patients were encouraged to reflect upon occasions where they successfully resolved problems with internal tension and frustration without using violent strategies. Focus during the group meetings was on factors that contributed to why these episodes were "non-problem" exceptions.

As patients adopted this positive perspective, they were encouraged to think specifically about constructive behaviors and situational elements they might try to duplicate in future challenging situations.

Results

During a two month period following a month of the solution-focused emphasis, a modest behavioral improvement on some of the outcome measures was observed.

Number of self-injurious behavioral episodes

Number of assaultive behavioral episodes

Number of episodes requiring seclusion

Number of episodes requiring restraint

Number of episodes requiring 1-to-1 staff supervision

Use of PRNs increased somewhat during the follow-up period, suggesting that use of calmatives was a commonly used alternative to acting out. While in some populations this would be viewed quite negatively, and such an increased use of medication always needs to be viewed with caution and monitored closely, in this highly compromised inpatient group, appropriate requests for PRNs were seen as adaptive.

Since no wait-list or placebo control group was employed, only limited inferences about the causal impact of the incorporation of solution-focused strategies are warranted here. However, these encouraging preliminary findings suggest the need for more rigorously controlled extensions of the current work.

Techniques

EXCEPTIONS ELICITATIONS

With a goal statement:

When are you already doing some of what you want?

With a problem statement:

When doesn't the problem happen?

CONTEXTUAL DIFFERENCES

What is different about these times?

SPECIFICATIONS

Within the patient's frame of reference:

What do you do differently?

How do you think differently?

From outside the patient's frame of reference:

How are you being perceived by others as acting differently?

If others think you are acting differently, how do they act differently?

BRIDGING AND FRAMING

So, as you continue to do these things, will you think that you are on the beginning of a track to getting what you want out of coming here?

PURSUING THE GOAL OF CONTINUING EXCEPTIONS

How will you keep this going?

How do you predict that you will keep this going?

How will others know that you are keeping this going?

The Criteria For a Well-Defined Goal

	CRITERIA	KEY WORDS	SAMPLE QUESTIONS
1.	In the positive	"Instead"	"What will you be doing instead?"
2.	In a process form	"How"	"How will you be doing this?"
3.	In a here-and-now	"On track"	"As you leave here today, and you're on track, what will you be doing differently or saying differently to yourself?"
4.	As specific as possible	"Specifically"	"How specifically will you be doing this?"
5.	In the patient's control	"You"	What will you be doing when that happens?
6.	In the patient's language	Use the patient's expressions	

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